Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
The chief executive of NHS England. NHS England, PO Box 16738, Redditch, B97 9PT

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 11/04/2019 I commenced an investigation into the death of Siân Frances HEWITT aged 25. The investigation concluded at the end of the inquest on 05 March 2020. The conclusion of the inquest was:

I a Massive Pulmonary Thromboembolism

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

On admission to the Campbell Centre Milton Keynes on the 13th March and during the period of her admission 2019 there was a failure to carry out a VTE risk assessment this was in breach of the CNWL protocol. There was no plan put in place for adequately maintaining and monitoring her fluid intake There was a delay in administering intra-muscular Aripiprazole that resulted in her mania not being brought under control. There was a lack of close ongoing review of her care by a consultant psychiatrist. When Sian failed to respond to her treatment there was a failure to escalate her care and involve more senior members of the care team. There were multiple opportunities to realise that Sian had become unwell on 6th April 2019 that were missed and therefore here was a failure to start effective CPR

My narrative conclusion at the End of the inquest was:

Sian Hewitt died, on 6th April 2019 at Milton Keynes University Hospital where she was taken after collapsing on Willow Ward at the Campbell Centre, there was a failure to recognise how seriously ill she had become and this resulted in lost opportunities to treat her appropriately that may have prevented her death. There was a failure to appropriately treat her to control her mania and a failure to assess, recognise or treat the risks of her developing a pulmonary embolism and these failure's may have caused or contributed to her death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

It would appear from the circumstances of Ms Hewitt‘s death that the NHS are unable to provide a place of safety for those who are suffering from Asperger's syndrome, or indeed other forms of autism, when they are also suffering additional mental health problems such as bipolar. The Campbell Centre in Milton Keynes was not an appropriate placement and I believe this matter should be looked at by NHS England and for more appropriate provision to be made for such patients.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 October 2020. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;
The Family of Miss Hewitt
Central North West London NHS Foundation Trust
Milton Keynes University Hospital

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

9

Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 21 August 2020